STATE OF TENNESSEE
DEPARTMENT OF HEALTH
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE, METRO CENTER
NASHVILLE, TN 37243
www.tennessee.gov

BOARD OF ELECTROLYSIS EXAMINERS
Local (Nashville Calling Area) 615-532-5155
Nationwide (toll free) 1-800-778-4123 Ext. 25155

Dear Applicant:

Thank you for your request for an application for licensure as an Electrologist or an Instructor. In response to your request, this packet contains information relative to obtaining licensure as an Electrologist or an Instructor in Tennessee.

The requirements for application are supported by board rules and regulations and T.C.A. 63-26-101 et. seq. Please read the instructions, statute, and rules and regulations carefully prior to applying. **Application fees are non-refundable and all documents submitted to the Board becomes a part of your file and are not returnable.** It is suggested that documents listed in the instructions and checklist, which will be sent by a third party, be requested upon receipt of this packet.

Upon initial review, if your application is incomplete or the supporting materials have not arrived in our office, a deficiency letter will be sent to you by certified mail. **You will have 30 days from the date of receipt to correct the deficiency or the file will be closed.** Should you desire credentialing by the Board at a later date, you will be required to reapply.

It is the applicant's responsibility to keep the Board notified whenever a change of name or mailing address occurs. Such notification must be in writing, and you must reference your profession and the Board in your correspondence. A change of name request must be notarized and state the reason for the change.

This application packet has been designed so that you can complete and submit your application on a step-by-step basis. PLEASE READ ALL THE MATERIALS AND INSTRUCTIONS CAREFULLY BEFORE BEGINNING.

Every effort will be made to keep you informed, in writing, of the status of your application and to process your application in a timely, efficient, manner. We look forward to licensing you as an Electrologist in Tennessee.

Applicant Check Sheet

Applicant by Exam:

1. Complete application package in its entirety – sign and notarized.
2. Attach a recent, full-faced, signed passport photograph. Photo must be signed on the front or back.
3. Attach correct amount of fees according to fee schedule. Attach check or money order for the proper amount made payable to the Tennessee Board of Electrolysis Examiners.
4. Submit notarized copy of high school diploma or proof of equivalent education.
5. Education:
   General Education Course Work: Submit official transcript directly to administrative office from the college or university. Transcript issued to the student not acceptable.
   Electrologist Training submit evidence of completion of Electrology Program. Such evidence must be sent directly from the school to administrative office.
   AEA or SCME Exam Scores – proof of passing one of the two exams. Scores must be submitted directly to administrative office from AEA or SCME.
6. Reference letters: submit two original reference letters to the Board.
7. Proof of age: Notarized copy of birth certificate, valid drivers license, passport or naturalization papers.
8. Verification of license or certifications you've held in any other state or profession sent directly to administrative office.

Limited License Applicant:

1. Completed application package in its entirety – sign and notarized.
2. Attach a recent full-faced signed passport photograph. Photo must be signed on front or back.
3. Attach correct amount of fees according to fee schedule. Check or money order should be made payable to Tennessee Board of Electrolysis Examiners.
4. Submit notarized copy of high school diploma or proof of equivalent education.
5. Filed a Notification of Training form or letter to the Board at least 10 days prior to beginning the limited licensure training program.
6. Provide an original written statement from the supervising dermatologist that he provided direct supervision of 600 hours during the limited license training, the provisions of T.C.A. 63-26-108(b) not withstanding;
7. Pass the Electrology written and practical exam.

Reciprocity:

1. Complete application package in its entirety – sign and notarized.
2. Attach a recent full-faced signed passport photograph. Photo must be signed on front or back.
3. Attach correct amount of fees according to fee schedule. Check or money order should be made payable to Tennessee Board of Electrolysis Examiners.
4. Hold a valid, unrestricted license in another state, which has license requirement substantially equivalent to those of Tennessee or have practiced Electrology five (5) years or more in a state which does not require a license for such practice; and such person is a Certified Electrologist.
5. Provide adequate evidence that the Electrology license held in another state was obtained after passing an examination which is substantially equivalent to the examination required by Rule 0540-1-.08.

Instructor:

1. Complete application package in its entirety – sign and notarized.
2. Attach a recent full-faced signed passport photograph. Photo must be signed on front or back.
3. Attach correct amount of fees according to fee schedule. Check or money order should be made payable to Tennessee Board of Electrolysis Examiners.
4. Submit notarized copy of high school diploma or proof of equivalent education.
5. Hold a valid or unrestricted Electrology license in Tennessee.
6. Provide an affidavit or evidence of practicing for at least five of the last ten years prior to application.
7. Education:
   General Education Course Work: Submit official transcript directly to administrative office from the college or university. Transcript issued to the student not acceptable.
   Electrologist Training submit evidence of completion of Electrology program. Such evidence must be sent directly from the school to administrative office.
   AEA or SCME Exam Scores – proof of passing one of the two exams. Scores must be submitted directly to administrative office from AEA or SCME.
8. Reference letters: submit two original reference letters to the Board.
9. Proof of age: Notarized copy of birth certificate, valid drivers license, passport or naturalization papers.
10. Verification of license or certifications you've held in any other state or profession sent directly to administrative office.
11. Pass the Electrology instructor written and practical exam.

ELECTROLOGIST BY EXAMINATION APPLICANTS/ LIMITED LICENSE

3856)001	$150.00
3856)001	$100.00
3856)001	$100.00
3856)006	$ 10.00
	$360.00

RECIPROCITY APPLICANTS

3856)001	$150.00
3856)001	$150.00
3856)001	$100.00
3856)006	$ 10.00
	$410.00

INSTRUCTOR APPLICANTS

3856)001	$175.00
3856)001	$100.00
3856)001	$100.00
3856)006	$ 10.00
	$385.00

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APPLICATION FOR LICENSE

Read all the information in the packet prior to completing this application. Give all the information requested using extra sheets if needed. Incomplete applications will not be processed. To expedite processing, do not return instructions. Return only your application, fees, and requested supporting materials.

Please select **one** licensure method from below:

❒ Electrologist by Examination ❒ Electrologist by Reciprocity ❒ Electrology Instructor ❒ Limited

IDENTIFICATION INFORMATION

Name _____
First Middle Last Maiden

Mailing Address (all correspondence from the Board will be mailed to this address)

Street _____

City _____ State _____ Zip Code _____

Telephone: (Home) (____) _____ (Business) (____) _____

Social Security Number _____ Sex*: ( ) Male ( ) Female

Date of Birth: _____ Place of Birth: _____

EXAMINATION INFORMATION

Have you ever taken the National Certification Examination? ( ) Yes ( ) No

If yes, date of examination: _____ and request verification be sent to the Board from the examining agency.

*Optional-statistical information only

Employment History

List in chronological order a brief description of your work experiences. Include dates, locations and specific duties.

Current Employer: [_____]

Street Address: [_____]

Dates: [_____] Job Title: [_____]

Supervisor's Name: [_____] Job Title: [_____]

Major responsibilities: _____
_____
_____
_____
_____

Previous Employer: [_____]

Street Address: [_____]

Dates: [_____ _____ _____ to _____ _____ _____]

Job Title: [_____]

Supervisor's Name: [_____]

Job Title: [_____]

Major responsibilities: _____
_____
_____
_____
_____

Previous Employer: [_____]

Street Address: [_____]

Dates: [_____ _____ _____ to _____ _____ _____]

Job Title: [_____]

Supervisor's Name: [_____]

Job Title: [_____]

Major responsibilities: _____
_____
_____
_____
_____

EDUCATION HISTORY

Name of High School and Location	Dates Attended	Certificate or Degree

Name of College and Location	Dates Attended	Certificate or Degree

Name of School of Electrologist and Location	Dates Attended	Certificate or Degree

LICENSURE HISTORY

List below all states in which you have ever been or currently are licensed (in any profession). If you have not previously been licensed, mark this section N/A. Submit a copy of Attachment 1 to all states regarding such licensure. Verification must be sent directly to the Tennessee Board of Electrolysis Examiners from the Licensure State.

State	License Number	Date Issued

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative,** attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application*.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to exercise reasoned professional judgments and to learn and keep abreast of developments in your profession; and

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devises, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	_____	_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?	_____	_____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.]

COMPETENCY INFORMATION CONTINUED

		YES	NO
2.	Do you currently use chemical substances?	_____	_____
	a. If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	_____	_____
3.	Are you currently engaged in the illegal use of controlled substances?	_____	_____
	a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5.	If you have ever held or applied for a license or certificate to practice Electrology in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7.	Have you ever failed an Electrology licensure examination?	_____	_____
8.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
9.	Have you ever been rejected or censured by a professional society?	_____	_____
10.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered against you; or	_____	_____
	b. Have you ever had settlement of any legal action rendered against you; or	_____	_____
	c. Are there any legal actions pending against you or to which you are a party?	_____	_____
11.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application and signed photos, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations and agree to abide by them in the practice of Electrology in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include an interview.

RELEASE to the Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice Electrology.

AUTHORIZE the Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and any other qualifications;

RELEASE from liability the Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

In order to comply with federal statutes, the Board of Electrolysis Examiners is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report the individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such other purposes as are allowed by state and federal law.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me, this _____ day of _____, 20____.

_____
NOTARY PUBLIC

Affix Seal Here

My Commission expires _____

Attachment 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE, METRO CENTER
NASHVILLE, TN 37243
www.tennessee.gov
TENNESSEE BOARD OF EXAMINERS IN ELECTROLYSIS
LOCAL CALLS 615-532-5155
TOLL FREE CALLS 1-778-4123 EXT 2-5155

ELECTROLOGY TRAINING VERIFICATION

Complete part A of this form and mail to the Electrology school where you obtained training. (You are authorized to photocopy this form.)

Part (A) Must Be Completed By The Applicant

I am applying for licensure as an Electrologist in the state of Tennessee. I completed the Electrolysis training at your facility on _____. The Tennessee Board of Examiners In Electrology requires that verification of my training is to be submitted directly from the school to the Tennessee Board. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board.

Signature _____

Print Name _____

Date _____

Part (B) Must Be Completed By The Electrolysis School Director

I _____ certify that the above named individual was enrolled at the school of _____, beginning date _____ ending date _____ and has completed the required electrology training as indicated of 600 course hours.

Subject	**Theory Practical Hours**
Electrology Theory	
General Orientation	_____
History of Electrolysis	_____
School Program/School Rules	_____
State Law, Regulations, Ethics	_____
Supplies	_____
Causes of Hair Problems	_____
Structure of Hair and Skin	_____
Neurology and Angilogy	_____

Microbiology, Bacteriology and disinfecting, Hygiene _____
Principles of Electricity and equipment _____
Modalities of Electrolysis _____
General Treatment Procedures _____
Development of a Practice _____

Total Theory Hours _____

Clinical Experience

Draping and Positioning _____
Legs _____
Arms _____
Face _____
Torso _____

Total Clinical Hours _____
Total Training Hours _____

Remarks:

Signature _____
Title _____
Date _____

Return directly to:

Tennessee Board of Electrolysis Examiners
227 French Landing, Suite 300
Heritage Place, Metro Center
Nashville, TN 37243

Attachment 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE, METRO CENTER
NASHVILLE, TENNESSEE 37243

BOARD OF ELECTROLYSIS EXAMINERS
(615) 532-5155
or
1-800-778-4123 Ext. 5155

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your educational program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a license or limited permit to practice as an Electrologist in the State of Tennessee. The Board of Electrolysis Examiners requires verification of educational attainment. Please forward an original transcript showing degree awarded and bearing the institution's official seal to the Board's address below.

Applicant's Full Name: _____
(First) (Middle/Maiden)

Applicant's Address: _____

_____

Applicant's Social Security Number: _____ - _____ - _____

Applicant's Student Identified Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

Board of Electrolysis Examiners
227 French Landing Suite 300
Heritage Place, Metro Center
Nashville, TN 37243

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

Attachment 3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING SUITE 300
HERITAGE PLACE, METRO CENTER
NASHVILLE, TENNESSEE 37243

BOARD OF ELECTROLOGY EXAMINERS
(615) 532-5155
or
1-800-778-4123 Ext. 25155

VERIFICATION FROM OTHER STATE CERTIFICATION BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the certification board in **EACH** state where you **hold or have ever held** a certificate/license/permit to practice any profession. (Copies of this form can be used.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish the contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a **(circle one)** license/certificate/permit to practice _____
(Profession)
with **(check one)** License / Certificate / Permit number _____ on _____
(*Date)*
in the State of _____. The Tennessee Board of Electrolysis Examiners requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Electrolysis Examiners.

Date: _____ _____
Applicant's Signature

_____
Applicant typed or printed name

To Be Completed By Administrative Office of State Certification Board

Name In Full As It Appears On License/Certificate or Permit:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

State: _____

Date Issued: _____ Date of Expiration: _____

Basis of issuance: _____ Endorsement/Reciprocity with _____
(Check One) *(State)*

_____ Written Examination _____
(Name of Exam)

The License is currently active and registered? ____ Yes ____ No

Is there any derogatory information on file? ____ Yes ____ No If yes, Please attach supporting documentation.

_____ _____ _____
Authorized Signature Title Date

PP/G4015159/ELE

PH 3573
Rev. 06/06

RDA S 836-1

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY

PRACTITIONER

PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWORD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health**.**

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider</u> to:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records.</u>**

✓CHECKLIST

Before you mail your questionnaire:

- ☐ Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

- ☐ Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

- ☐ Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-888-310-4650. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: _____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(_____)_____**(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License #**_____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License#**_____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date:_____
(Signature of Provider)

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